IMD Study

Phase One Report
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INTRODUCTION

The Department of Mental Health (DMH) is conducting a study of Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases (IMDs). DMH has contracted with Beverly Abbott, J. R. Elpers, Pat Jordan and Joan Meisel to conduct the study. Two consultants work with the project team, Darlene Prettyman and Alice Washington; they offer additional expertise in family member, consumer and cultural competence issues.

The study has three parts:

> ***Phase I: Background and Basic Information Gathering.*** This phase consists of two parts: interviews with counties and collection and analysis of statewide IMD utilization data. It is designed to create a framework for understanding how IMDs fit into counties' systems of care and for identifying hypotheses for what accounts for varying use patterns by county.
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> ***Phase II: In-depth Information Gathering in 6 – 8 Counties.*** This phase of the study will explore in greater depth the factors that influence varying levels of usage of IMDs in a variety of selected counties. Participation as a study site for this phase of the study will be voluntary. The contractors will conduct site visits to the participating counties to gain a full understanding of the contextual factors that impact IMD usage and will collect client-level data on individuals entering and leaving IMDs during an approximately one-year period to better understand the process and circumstances surrounding actual use of these facilities.
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> ***Phase III: Analysis and Development of Best Practices and Recommendations*** Using the empirical information from the client-level data and the qualitative understanding of the unique circumstances in each county, the contractors will identify strategies and best practices for lowering, as appropriate, the usage of IMDs. A checklist for counties to review and assess how well their system addresses the key factors that impact IMD usage will also be developed.

This brief report summarizes the Phase I work. It is divided into the following three sections:

- Part A: Interview results
- Part B: Statewide data collection
- Part C: Observations and criteria for selection of Phase II counties

For the purpose of Phase I of the study and unless otherwise noted, the use of the term "IMD" in this report refers to a level of care definition: institutional care for the purpose of mental health treatment and services, and includes state hospitals, Skilled Nursing Facilities (SNFs) which specialize in mental health treatment, and Mental Health Rehabilitation Centers (MHRCs).

The term "IMD" originally came from a federal government definition. Title 42, Code of Federal Regulations, Section 435.1009(b)(2), defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." IMDs in California generally include facilities in the following licensing categories, if the facility has 17 beds or more: acute psychiatric hospitals, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs) with a certified special treatment program for the mentally disordered (STP), and mental health rehabilitation centers (MHRCs). The definition is important because under Title 42, CFR, Section 435.1008, "FFP is not available in expenditures for services provided to . . . Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter…" Some counties and providers have created parts of a SNF for mental health consumers that occupy less than 50% of the beds. In this situation the SNF is not an IMD under the Federal definition, such facilities are included in this study, however, as we are primarily interested in a level of institutional care rather than a reimbursement category for Medicaid purpose. For similar reasons, state hospitals are also included in this study.

As described below, county interviews confirmed that mental health programs use all of these facilities either for a relatively short-term step-down placement between acute care and community placement or as a longer-term placement for consumers whom counties have not been able to find appropriate community placements.

PART A: INTERVIEWS

This part of the report summarizes the results from telephone interviews with 35 of the 40 counties in the state with a population greater than 50,000 (see Appendix A for the list of counties). These counties together constitute roughly 90% of the state's total population. An additional four counties with less than 50,000 population provided written answers to the interview questions. The Mental Health Director of each county was sent a brief description of the study and a copy of the interview protocol and was asked to include in the telephone call whomever s/he felt could provide useful information. The counties' co-operation in the interview process was outstanding.

The interview results are presented in five parts:

- General information about the counties IMD usage
- How counties authorize access to IMDs and monitor consumers in IMDs
- Needs of consumers and counties that make community placements challenging
- County and state actions that would assist reduction in IMD usage
- Under 50,000 population counties and consumer/family perspective

To as great an extent as possible, this report uses the words counties used in their interview responses. As discussed later in this report, many counties did not use recovery-oriented language. The language used by the persons being interviewed has been reported in order to more accurately reflect current program realities and language.

GENERAL INFORMATION ABOUT COUNTIES' IMD USAGE

Most counties use multiple facilities.

The average number of different facilities that the counties reported using was 6.5 with a median of 6. Interestingly, many of the small counties used as many different facilities as did the larger counties.

Numbers of Facilities Used By Size of County[1]

Population	50-250,000	250-500,000	500,000 to 1 M	1 – 3 M	LA
Number of counties	13	6	6	7	1
Average # facilities	5.4	6.5	8.5	7.1	11
Median # facilities	5.0	5.5	7.5	7	11
Range of # of facilities	3-9	3-11	3-16	4-12	11

For some counties the use of many facilities was a conscious strategy that allowed them to meet individual needs of consumers and to move consumers should the treatment in one facility become "stale." For others, the use of multiple facilities was more a matter of necessity because they could not be assured of gaining access to a particular IMD when they needed a bed.

[1] Two counties (with a total current census of 83) indicated a general contract with Crestwood facilities without specifying which facilities were actually currently being used.

A few counties use facilities within their county almost exclusively, but some counties with facilities within the county also use out-of-county facilities.

Twenty-three of the 35 counties have IMD beds located in their county. The table below breaks the counties into three groups: five counties that use in-county facilities entirely or almost entirely; nine counties that utilize in-county facilities for about half their census (45-65%); and nine counties that send more than 55% of their clients out-of-county.

In-County and Out-of-County Census for Counties with an In-County IMD

	Number (and %) of counties	*In-county census*	*Out-of-county census*
Counties with between 75 and 100% of their census in in-county facilities	5 (22%)	1372	69
Counties with between 45 and 65% of their census in in-county facilities	9 (39%)	654	639
Counties with less than 45% of their census in in-county-facilities	9 (39%)	219	422
TOTAL	23 (100%)	2,245 (67%)	1,130 (33%)

Overall, two-thirds of the census (of counties with facilities in-county) is in in-county facilities. This is because four of the five counties that have at least 75% of their residents in in-county facilities are large counties.

Some counties indicated a clear advantage to having clients in-county in terms of allowing for a) better monitoring and b) more opportunities to prepare the consumer for community life (by visiting possible residential sites, by joining a community-based peer group, etc.). This advantage appears to be weighed against the potential for a better match between the client's specific needs and the strengths and capacity of the facility(ies) located within the county. This would be less of a problem in the larger counties since they have more in-county facilities from which to select a placement for any individual consumer.

About half the facilities serve clients primarily from one county, but many have consumers from multiple counties.

The table below is based on the current census information provided by the counties interviewed. Counties indicated using 53 different facilities (excluding state hospitals). Fifty-five percent of the facilities representing about 60% of the total current census served only one or predominately (over 85% of the census) one county. Another 19% of the facilities had residents from two to five counties, with roughly 12% of the total census. The remaining quarter of the facilities (with 29% of the census) had residents from six or more counties.

Number of Counties Using a Particular Facility

Number of Counties Served by Facility	*Number (and %)* of Facilities	*Number (and %) of Census*
Facility has residents from only one county or 85%+ of residents are from one county	30 (56.5%)	2,117 (59%)
Facility has residents from two to five counties	10 (19%)	444 (12%)
Facility has residents from six or more counties	13 (24.5%)	1024 (29%)

The IMDs serve two major functions in the counties' adult system of care – one as a short-term step-down placement from acute care and the other as a long-term placement for selected clients.

Almost all admissions to the IMDs come from acute care facilities. The IMD is used when the county believes the client will NOT be able to be successful in the community if discharged directly from acute care. The function of the IMD is to provide additional time for the client to stabilize, to assist the client to acquire or strengthen community-living skills, and to develop an aftercare plan that will lead to a successful placement in the community. Counties consider these to be short-term placements, but the definition of short-term varied. Some talked about short-term as 30 days while others used the term to refer to stays of from 3 to 12 months.

The second major use of IMDs is for a relatively small subset of clients who are expected to remain in the IMDs for a long period of time, in some cases with no anticipated discharge.

Most counties articulated a difference between MHRCs and IMDs, but a significant minority believe the difference exists only on paper.

One of the study issues is the extent to which the different licensure and reimbursement categories make a difference in the facilities' services and their use by the counties. Some of the interview questions began an exploration of this by asking what the counties perceived as the differences between IMDs (in this case referring to SNFs either reimbursed by Medi-Cal or not) and MHRCs.

Thirty of the 35 counties used at least some MHRC beds and so should be in a position to articulate differences between the kinds of services rendered and/or the kinds of clients served. The MHRCs were viewed as taking clients with greater rehabilitation potential, focusing more on recovery and developing independence, and having shorter lengths of stay. A few counties said the distinguishing feature was the greater capacity of the IMDs (as SNFs) to take clients with more significant medical complications.

Five counties indicated that while these facilities are supposed to reflect these differences they do not perceive any difference in who the facilities accept or the nature of the treatment.

Most counties indicated using at least some of the IMDs for specific purposes.

The most frequent distinction was between facilities used for the step-down function versus the long-term placements. For example,

- We use different facilities for different roles, e.g. " A" for long-term and "B" and "C" for step-down.
- "A" more long-term and "B" more short-term.
- "A" is short-term; others are long-term and special populations.
- "A" for very chronic who may be there almost forever.
- "A" for first-time IMD clients where they hope to move them back to community quickly.
- Two IMDs are long-term with little chance of discharge.

A few counties made a distinction between a subacute and a regular level of care with the former reserved for clients with greater or more acute needs and receiving higher reimbursement. Some counties talked about particular IMDs having special programs, for Asians, forensic patients, medical problems too severe for other facilities, persons who are deaf, consumers with both mental illness and developmental disabilities, and those with head injuries.

And two counties indicated trying to match all their individual clients with particular IMDs rather than distinguishing just between major categories or very special needs.

- Important to carefully match individual client's needs to capacity of particular IMD.
- The case manager thinks the programs have different areas of expertise and so tries to match the particular needs of the client to the programs strength.

State hospitals appear to play a placement of last resort function for many counties.

A few counties mentioned that the state hospitals are used for their most difficult clients, for example, those who:

- Are assaultive and unmanageable.
- Have greatest severity, e.g. are assaultive and have failed other placements.
- Have specialized needs e.g. burned out IMDs, aggression, medical needs.

Five counties also indicated that they occasionally used their other IMDs as a transition step between placement in the state hospital and placement in the community.

Conservatorship plays an important role in the use of IMDs.

A number of counties identified issues with conservatorship as contributing to issues with IMD usage. The placement of the conservatorship function in county government, the nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affected IMD utilization in a number of counties. The original interview protocol did not include questions about

conservatorship but after the issue was raised by some counties, questions were added to the protocol (See Appendix B for a copy of the interview protocol). Examples of issues and differences are:

- In some counties being on conservatorship always means placement in IMDs, i.e. the conservatorship is terminated when the client is discharged from the IMD.
- In one county the respondent complained that the conservator kept consumers on conservatorship in the community and that was not consistent with the recovery model i.e. if they could live in the community they could be off conservatorship.
- Another county responded that the conservator dropped individuals as soon as they were discharged from an IMD, therefore not giving clients a chance to adjust.
- Some counties found the conservators helpful in monitoring clients in IMDs while others felt that they were not helpful.
- One county also mentioned that because of budget cuts conservators have become more conservative and are reluctant to place clients in the community because of difficulty in monitoring them.
- A few counties noted more difficulties with private than public conservators, particularly in regard to an unwillingness to allow discharges from IMDs into the community.

The issue of conservatorship as a whole is beyond the scope of this study. However to the extent possible, its impact on IMD utilization will be explored in the case study counties.

Answers about cultural competence and the recovery philosophy were ambiguous.

The responses to our questions on cultural competence and the recovery philosophy raised questions about the extent to which these are being implemented in IMDs.

- Respondents who were very knowledgeable about cultural competence in two large counties (one in the south and one in the Bay Area) said that cultural competence was very limited in IMDs. Other counties using the same facilities felt differently.
- Counties using the same facilities responded differently on the recovery question as well. In general, we noted that the language of those we interviewed did not always synchronize with recovery vision; words and phrases like “meds compliant”, “following staff direction”, “maintenance” etc. are different words than those used in the recovery vision.

It is difficult to really understand these two issues in a short telephone interview so the above represents our preliminary impressions. Both of these issues will be explored in greater depth in the Phase II case study counties. We will select case study counties to include those with a diverse adult population. We will also in Phase II delve more deeply

into how the counties and the IMDs implement the recovery vision with these clients who have serious psychiatric disabilities.

Recidivism data is not routinely tracked and varies considerably among counties that had data.

Only ten of the counties interviewed either had or could fairly easily get information on the percentage of their discharged clients who re-entered an IMD during the year following their discharge. Four of the ten counties reported high recidivism rates (from 32% to 52%) while the other six reported low rates (3% to 13%). We are uncertain at this point whether these reflect real differences or whether counties used different methodologies in calculating recidivism. We will gather this data more precisely from the case study counties and attempt to ascertain whether the recidivism rates vary with use patterns and philosophies.

Similarly, the counties that just guessed at their recidivism rates differed considerably. Four guessed relatively high rates (20% - 50%) while three guessed it was relatively low (10% or under).

ACCESS AND MONITORING

The interview asked a series of questions about the county's process for admitting a consumer to an IMD and for monitoring the consumer's progress while in an IMD. The following represents a general picture of these processes. A more in-depth analysis of these processes will be a critical part of the Phase II work in the case study counties.

ACCESS

Almost all of the counties have a standard centralized process for authorizing admissions to IMDs.

The concern about the high cost of IMD care has led almost all of the counties to adopt some type of central authorization process. Many counties indicated that these had either been put in place or altered within the last few years, largely in response to fiscal constraints.

There are three counties that appear to not have a centralized process. One allows direct referral from acute care hospitals to IMDs with notification of the county after admission by the IMD. Two others appear to place the decision about placement with the consumer's regional treatment team.

The counties use a variety of centralized authorization processes, in part reflecting differences in the size of the county.

Eighteen counties rely on some type of placement committee to review requests for and make decisions about IMD placement. These 18 include the smallest to the largest counties.

Eight counties – mostly smaller counties but also one of the large counties – have a single person in their departments of mental health who signs off on every IMD admission.

Three counties appear to have placement committees with membership that changes depending on the particular client. Two, for example include the treatment team currently responsible for the consumer's services and treatment.

Regardless of structure, counties tend to use management or supervisory staff who have clinical experience.

Where the county relied on a single staff person to authorize admissions it was almost always a program manager, a supervisor, a clinical director, a medical director, or a director or deputy director.

When a team was involved it invariably included licensed clinical staff (masters-level social workers, psychologists, and/or registered nurses) as well as program managers and supervisors of either case management or treatment teams. There was also often a director of placement or a long-term-care coordinator. Other staff types mentioned were quality assurance/improvement, liaisons with the acute care facilities, and discharge planners from the hospitals. While all placements have to be approved by the conservator they sometimes functioned as a regular part of a placement team.

Here are a few examples:

- QI/Managed Care Program Manager in concurrence with Medical Director.
- Consensus of conservator, inpatient MD, and social worker.
- Attending psychiatrist, Public Guardian, and program manager who is a licensed psychologist.
- Master's level clinician and social worker
- Clinical Program Manager with sign off by Mental Health Director.
- Multidisciplinary team, then approved by Adult Program Manager with final review by Medical Director and Adult Administrator.
- Head of adult system of care, IMD case manager, psychiatrist, conservator, and discharge planner from hospital.

Monitoring

All counties receive periodic updates from IMDs on clients' progress.

Counties generally rely upon IMD forms and procedures for this routine tracking of their consumers while in the IMD. IMDs appear to send reports either monthly or quarterly; some IMDs send minutes of treatment conferences. Some counties require the IMDs to complete a county or STP form for continued authorization.

Most counties also reported that they have periodic telephone contact with the IMDs.

More active monitoring through on-site visits by county staff occurs at least quarterly.

All but two counties indicated that county staff visited IMDs to either talk to the treatment team, and/or review resident charts, and/or interview the resident at least quarterly. More frequent monitoring occurred with facilities that were either in the county or in near-by counties and with facilities in which the county had a significant number of their consumers. The frequency of these visits range from almost daily to weekly to twice a month to monthly.

Some counties also indicated an increase in frequency of monitoring as a consumer approached the time of discharge.

While counties rely on the same types of procedures, the intensity and scope of the monitoring varies across the counties.

Here are some examples of the ways in which counties mix and match these various monitoring activities.

- One moderately-sized county (250 – 500,000) with no in-county IMDs has one staff person do on-site monitoring of all the IMD clients at least once a month and more often near discharge. She also attends IMD quarterly reviews and receives copies of IMD treatment team minutes.
- One small county (50-250,000) with no in-county IMD receives a monthly status report on its clients from one IMD and quarterly reports from two other IMDs. A case manager who is responsible for discharge planning reviews client progress at least quarterly.
- One larger county (750,000 – 1 M) visits its in-county IMD daily or weekly while two RNs visit the out-of-county IMDs at least monthly. A routine assessment is done on all consumers when they enter the IMD and again when they are ready for discharge. A linkage case manager is brought in when the client is ready to be discharged.
- One larger county (500,000 – 1 M) has case managers who visit all IMDs at least monthly with more frequent visits at facilities (some in and some out-of-county) where they have more clients. They also receive reports (some in

writing and some by phone) from some IMDs quarterly and some more frequently.

- One smaller county (50 – 200,000) receives monthly reports from IMDs with a placement team that monitors the progress of all clients in IMDs and that meets three times a week for two hours.
- One large county (2 – 3 M) get a quarterly certification form from the IMDs. A long-term-care unit monitors facilities quarterly during which they see some residents. All residents are seen at least yearly.
- One smaller county (50-200,000) relies on the IMDs charts. A program manager visits an in-county facility weekly and out-of-county facilities monthly. The case manger will have weekly phone contacts with the facilities about their particular clients.
- One moderately sized county (250-500,000) uses STP forms but really relies on site visits for monitoring. Their standard is that the regional team case manager sees their clients every 3 weeks which entails a conversation with the client and the staff and a review of the IMD chart.

The conservator also plays a role in the monitoring of IMD residents.

As noted elsewhere, almost all clients in IMDs are on conservatorship. Many counties noted how their monitoring process related to that of the public conservator. In some instances the Public Guardian has mental health staff assigned to their office who conduct the monitoring. In other instances, the Public Guardian may accompany the county mental health staff during visits to facilities. The frequency of Public Guardian contact varied, with one county including the Public Guardian in the three week standard for face-to-face contact, while most indicated a quarterly visit.

CONSUMER AND COUNTY NEEDS

The interview contained a number of questions about what might cause consumers to be admitted to and/or stay in IMDs longer than necessary from a clinical or programmatic perspective. One approach to this issue is to identify the characteristics of consumers that challenge program's abilities to successfully support them in the community. One can then use this information to explore the kinds of services that might be useful to meet the needs of these consumers in the community thus lessening any inappropriate time in an IMD setting.

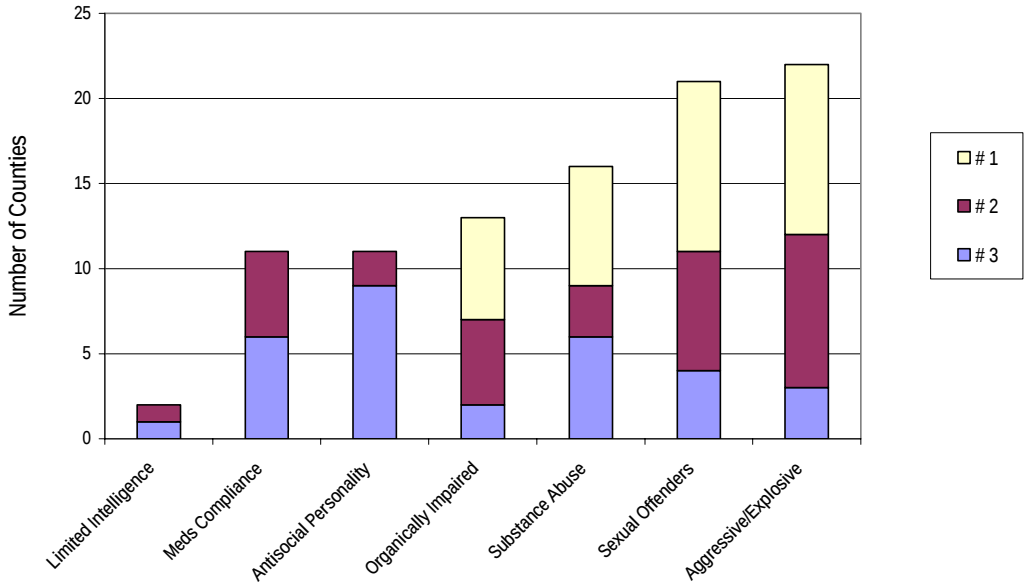
Another approach is to identify gaps or needs from the perspective of the county's System of Care. The interview took two cuts at this. First it asked what community services would allow the county to place their current IMD consumers in the community. The second asked what resources were needed by the county to address general barriers to community placement.

Consumers Who Present Challenges to Successful Community Placement

Counties identified consumers who exhibit aggressive/explosive behavior and sexual offenders as the most challenging to serve in the community.

Counties were asked to rate seven different types of consumer characteristics in terms of most to least difficult to serve in the community. An additional "other" category was also included. *Figure 1* shows the number of counties who rated each of the types either as the hardest (#1), the second hardest (#2), or the third hardest (#3).

Figure 1
TYPE OF CLIENT MOST CHALLENGING TO SERVE IN COMMUNITY



Some counties noted that their ranking did not indicate overall county need since some consumers – namely those with a history of sexual offenses – were extremely difficult to place, but also fairly rare in their caseload. By contrast, clients who had substance abuse issues were not as challenging on an individual consumer basis, but the large numbers of consumers who fit this category make it a sizable problem for the county. This confounding of the challenges presented by an individual consumer with the number of consumers with particular kinds of behaviors will be further explored in our case study counties.

County Resource Needs

Housing-related resources were the most frequently mentioned resource that would help the county get their "present IMD residents out in the community."

The counties were asked an open-ended question about what resources were needed to get current IMD residents placed in the community. Fifty-one responses dealt with housing or housing-related resources. (Counties might be counted twice if they mentioned two separate housing-related resources.)

- Twenty-two responses cited board and care resources. Of these:
  - 10 indicated regular board and care
  - 11 indicated board and care with programming
  - 1 indicated board and care with a secure perimeter
- Twenty responses cited housing resources. Of these:
  - 12 indicated either housing generally or a range of housing options
  - 4 indicated affordable housing
  - 4 indicated supported housing
- Nine responses cited step-down or residential treatment facilities.

The next largest category was a range of intensive case management-type services: 14 counties cited either an Assertive Community Treatment, AB 2034 (integrated services), or intensive case management program.

Eleven counties mentioned a day program. Five of these indicated some type of vocational service; two each cited socialization programs, peer programs, and day treatment.

The last category of responses – 7 mentions – was more funding and/or more staff.

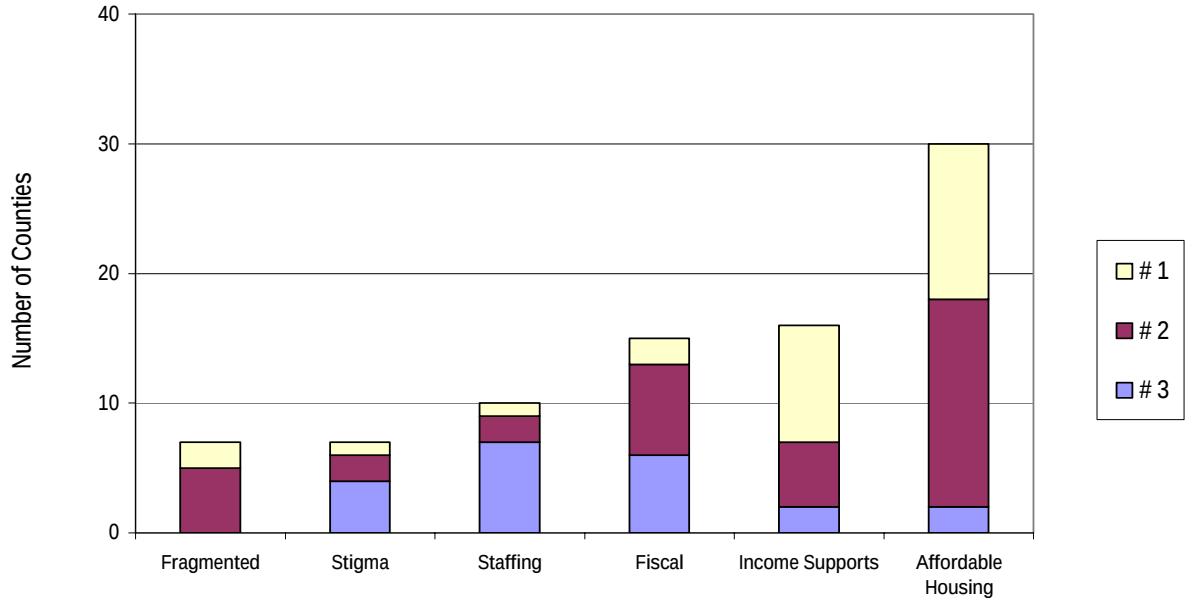
The importance of housing was reinforced by county responses to a question about the "most important general barriers to community placement."

A recent SAMSHA report "Overcoming Barriers to Community Integration for People with Mental Illness" identifies eight barriers to the creation and use of services that support persons with mental illness in the community: lack of income support and entitlements; lack of affordable housing; lack of competitive and supported employment; lack of access to culturally appropriate health care; fragmented services; fiscal barriers to individualized flexible services; stigma and discrimination; staffing shortages. We added to these three others: lack of access to culturally appropriate specific mental health services; undocumented immigration status; and legal and conservatorship barriers. The counties were asked to rank the three most important of these eleven general barriers to community placement.

Figure 2 shows the barriers most frequently rated within the top three. Affordable housing was rated in the top three by 30 of the counties, with 28 rating it as most or

second most important. The second most frequently ranked barrier was the lack of income supports and entitlements, followed by fiscal barriers to individualized, flexible services. Staffing shortages were next followed by stigma, usually within the context of neighborhood difficulty in the citing of residential services. The last of the top six was fragmented services.

Figure 2
MOST IMPORTANT BARRIERS TO COMMUNITY PLACEMENT



Most of the counties had at least some of the community services necessary to support consumers in the community.

In these relatively short interviews we were not able to obtain definitive information about each county's full adult system of care, but we did inquire about the availability (and number of slots) for some of the major types of service. We will explore the role of the relative amounts of these services in greater depth in our Phase II case studies. Here, we simply summarize the extent to which the counties reported that they had at least some of these services.

Number of Counties Reporting Having Community-Based Supportive Services

Kind of Service	*Number of Counties*	*Percent of Counties*
Intensive Outpatient	31	89%
Residential	24	69%
B/C with either supplemental rates or county patches	28	80%

All but four of the over 50,000 population counties had some intensive outpatient services (AB 34, ACT, ICM, MIOCR).[2] Almost 70% reported some type of residential program.

Most counties had specific information about the number of regular board and care beds available in their counties, but not all did. Eighty percent did report the number of board and care beds that received either a supplemental rate or a special county patch. A few counties noted that they "patched" (provided additional funding for) all the board and care beds they used, but the vast majority had far more regular board and care beds than those that received some type of supplemental funding.

COUNTY AND STATE ACTIONS

County Initiatives to Overcome Barriers

Counties were asked what actions they are taking to overcome the barriers to community placement that they identified. They were also asked which of these appear to be the most promising.

Housing-related actions were the most mentioned of the most promising initiatives.

Not surprisingly, some housing-related action was cited by 27 of the counties. Nineteen of these included their housing-related initiatives as among their most promising. These initiatives can be divided into two general categories: a) work with housing authorities and community collaborations around longer-term strategies for increasing affordable housing or residential treatment programs, or b) short-term work on increasing the immediate supply of placements. Examples of long-term initiatives included:

- A housing coordinator working with Housing and Community Development to develop a housing plan for people with disabilities.
- Working with a multi-agency housing workgroup that includes the Housing Authority, the Homeless Program, Social Services, Law Enforcement, Aging, and Adult Services to expand housing opportunities at all levels.

[2] The four that did not were among the smaller counties: one has a population in the 50-100,000 range; two in the 100-200,000 range; and one in the 200-250,000 range.

- Working with major players in housing including the Housing Authority and local realtors.
- Grant writer for housing grants.
- Created an IMD workgroup that has now expanded to be an adult SOC Advisory Committee that is taking a broad look at all housing options.
- Housing coordinator working with multiple housing forums and advocating with seven different housing entities including developing housing stock.

Examples of short-term efforts to increase housing availability include the following:

- Paying patches to board and care to keep housing in the community; working with board and care around a single supplemental rate.
- Collaborating more with board and care operators to maximize housing options.
- Contracting with board and care beds out of county.
- Use a lot of interim placement money while improving communication with board and care operators.
- Work more closely with Community Care Licensing to support residential care operators.
- Better supportive programming has been developed in community apartments.
- Begun meeting with residential providers to clarify expectations under their contracts.
- Supporting clients in getting housing certificates.
- Creating a centralized housing resource data base.
- Plan to cut four IMD beds in next six months and create nine supported housing beds.

Some counties reported successful efforts at expanding housing alternatives.

Examples of county efforts that have resulted in enhanced placement alternatives include the following:

- Non-profits developed independent living programs that have Medi-Cal reimbursable services available on-site.
- Opened a 16-unit apartment complex with Shelter-Plus Care funds.
- Opened 10 houses (50 beds) which are assisted independent living. Consumers rent apartments from NAMI which purchased the houses.
- Opened a 10-bed supported housing facility.
- Developed 12-bed social model transitional residential program with 24-hour staffing and a follow-up supported housing component including Section 8. About half the clients come from IMDs.
- Developed a contract with a housing development corporation for set-asides for affordable housing units. This is combined with supportive services through a contract with a local non-profit.

The second most promising activity was the use of intensive outpatient services.

Eight counties noted an expansion of their ACT/AB 2034/Intensive Case Management programs as most promising for clients in either preventing IMD placements or reducing recidivism. Some of the counties noted the use of these intensive services for a short-term, for example after a consumer is discharged from an IMD. Examples of county comments follow:

- ACT – very helpful in reducing recidivism.
- Intensive treatment team which selects consumers ready to come off conservatorship or at risk of going on conservatorship and works intensively with them over a two-month period.
- Using a combination of harm reduction and strength-based approach in AB 2034 programs.
- Short-term wrap-around focused teams that follow IMD clients up to 59 days following discharge.
- Targeted case management focusing on clients at-risk of long-term placement. Rather than waiting until hospitalized assess what they need to stay in the community and deliver it.

A few counties are engaged in reviewing and changing parts of their system of care to better address barriers to community care.

Five counties cited these system changes as the most promising of their activities. Examples of activities mentioned (whether or not counties cited them as their most promising activity) include the following:

- Reorganized some outpatient services in order to enhance the flexibility and responsiveness of the service system.
- Continue strategy to shift fiscal resources from IMD to fund augmented Board and Care and staff support.
- Try to limit conservatorship referrals.
- Trying to centralize placements.
- Revamp day rehabilitation program to focus on ex-IMD clients who need support to maintain in the community.
- High priority for outpatient clinics to see IMD clients immediately after discharge.
- Re-looking at whole adult SOC structure.

A question about unique or special programs highlighted other system and programmatic ideas.

We asked counties if they had any unique or special programs that might be relevant to the study. These could be either long-standing practices, policies, or programs or ones that had been newly devised. While some mentioned the kinds of housing alternatives

and intensive outpatient services already mentioned above there were also some other interesting practices that will warrant attention in Phase II of the study.

In addition to the programs cited above, there were a few others that counties felt were very successful. Most of these have been created and are viewed as fitting into specific parts of the system of care in a way that addresses problems that lead to IMD placement and difficulty being discharged from an IMD.

- An AB 1425 program that will allow the county to provide recovery model services to clients in independent living. Clients to be seen daily.
- A SHIA (supported housing) program that allowed the county to move some clients out of residential facilities thus freeing up slots for IMD clients.
- Transitional youth program that focuses on getting clients housing. Many of these clients moved from Level 14 group homes straight into IMDs.
- Older adult program staff by nurses who work with SNFs to keep clients in regular SNFs who would otherwise have to be in IMDs.
- Providing short-term (up to 59 days) of intensive wrap-around services to consumers discharged from IMDs.

Some counties cited system actions, including the following:

- Using only in-county IMDs that served only (or predominantly) the county's consumers. This allowed a greater congruence between the goals of the county and the IMDs.
- Tracking each client on the Multnomah Community Ability Scale starting at entry and then quarterly thereafter.
- Conducting routine quality of care surveys of contracted IMDs.
- Conducting medications training for staff of IMDs.
- "Mobilizing the whole system" to reduce usage, a multi-pronged effort including changes in gatekeeping, closer contacts with IMDs, and creating more step-down options.

State Activities

The counties were asked what were the two most important things that the state could do to reduce or eliminate their use of IMDs. Not surprisingly, all but two counties included more funding of some sort as one of their suggested actions.

Fourteen counties suggested some variation of additional funding for board and care homes.

These suggestions generally took two separate tacks. The more frequent was to increase the rates for general board and care for mental health clients (a) to overcome the lower rates paid for board and care beds by mental health compared to developmental disabilities and the elderly and b) to overcome inadequate SSI/SSP payments. Both of these problems were cited by the California Mental Health Planning Council's *Housing*

for California's Mental Health Clients: Bridging the Gap as reasons for the shortage of Board and Care beds.[3]

A second general thrust was to increase payments to board and care operators for supplemental services. For example:

- Higher funding for structured board and care programming.
- Offer grants for enhanced board and care services.
- Incentivize specialized "patches"

Twelve counties suggested additional funding for housing.

While some of the counties mentioned more money for housing alternatives generally, some indicated more specific ideas for funding, including the following:

- More housing grants like Shelter Plus.
- Funding to provide subsidies and support to landlords.
- Assist with low cost loans to purchase property.
- More funding for different kinds of supported housing.

Additional money for specific services was mentioned 16 times, while more money or more staff generally was mentioned nine times.

The most frequent specific service mentioned (nine times) was some type of very intensive outpatient program such as ACT/AB 2034/intensive case management. Other specific programs that counties wished could receive more funding included the following: short-term regional alternative to IMDs with aggressive and intensive programs to move clients into the community; flexible outpatient services; forensics team; vocational programs; SNFs with STP.

Some counties felt that up-front seed funds would be very useful.

Some counties directly reduce their IMD capacity through reducing the IMD budget and use the funds that are saved to create community alternatives, most of which are Medi-Cal reimbursable. Some counties find this strategy impossible because of the high demand for the IMD level of care. From this latter group came the suggestion that the state might provide start-up funds for community programs which could then be maintained with county funding through savings in IMD usage.

[3] One of the reasons for lack of Board and Care beds for MH clients "Other disability groups, such as those serving the developmentally disabled and older adults, are able to pay facility operators a higher rate to house their clients." Another reason sited is "The inadequate reimbursement rate under SSI/SSP makes the expense to run such a facility difficult."

Work on licensing standards and enforcement was the most frequently mentioned legal and regulatory activity that the state could pursue.

Seven counties mentioned licensing issues, most having to do with the Department of Social Services Community Care Licensing of board and care facilities. County mental health efforts to entice board and cares to take clients with more severe problems are blocked by the operator's reluctance to get in trouble with licensing regulations.

- Work with Community Care Licensing to develop standards for board and care operators accepting placements of adults with serious mental illness.
- Some help with licensing issues which residential providers cite as reason for not taking some clients.

Other regulatory issues mentioned were enhanced civil commitment procedures (four mentions) and allowing greater resource flexibility (two mentions).

Two others suggested actions were the DMH taking a technical assistance role and working more collaboratively with other state agencies.

There were six suggestions related to the state's playing a stronger role in program development, training, and sharing information about good programs, for example,

- Look at what other states are doing to implement Olmstead.
- Develop concrete plans about what to do with really tough clients, e.g. wanderers, confused, medical.
- Find ways to help counties get more effective services under Medicaid.
- Technical support and exposure to other mental health programs that have been successful in keeping IMD usage down.

Stronger collaboration with other state agencies was suggested by four counties. Two related to enhanced cooperation with the Department of Alcohol and Drug Program "to reduce administrative hassles around different funding, regulations, approaches, etc." and "to allow more flexible use of funds for dual diagnosis." Two others related to working with the Department of Health Services to "deal with organic brain syndrome issues, namely the placement of these people who are not mentally ill being given mental health diagnoses and being placed in mental health facilities" and "encourage flexible blended funding with Department of Health Services for those with brain injuries and medical problems."

Under 50,000 Population Counties and Consumer/Family Perspective

Interviews with counties with less than 50,000 population confirmed many of the same issues along with some unique concerns.

One of the study contractors discussed this study with attendees of the County Mental Health Directors (CMHDA) and a Small County Committee. That committee consists of 33 self-identified small counties, the largest of which are around 200,000 in population. Counties were invited to participate in interviews if they desired. The interviews with 11 of these counties with population over 50,000 are included in the data analysis in the main part of the report.

Interviews with four counties with population under 50,000 are not included above. The combined IMD current census for these four counties was nine consumers. The smaller resource base of these under 50,000 population counties makes it more difficult to have a full range of appropriate community resources for their consumers, and the lack of transportation is a barrier to receiving these services elsewhere. One of these counties noted that "rural communities lack the infrastructure for all types of services." Two of the four counties indicated they were just trying to maintain their current services, as one said, "we are trying to keep our heads above water." The smaller budgetary base places these counties at high financial risk since the presence of just a few clients needing IMD services can create a huge strain on their budget.[4]

The small county state hospital bed pool will be phased out in FY 03-04

Since Realignment there has been a shared bed pool for state hospital use which was managed by CMHDA. Access to these beds was controlled through a committee comprised of rotating membership from all the counties. The fiscal incentives actually encouraged greater use of state hospitals since the counties had to make a contribution to the pool whether or not they used the beds and only received back a portion of those funds if they did not use their bed allotment. The utilization management was also a significant burden on the counties. So, beginning in FY 03-04, the small counties will be billed only for the actual state hospital days that they use.

An interview with members of the DMH Client and Family Task Force raised concerns about the quality of care in IMDs and the process of transitioning to the community.

Specific concerns about the care in IMDs included the lack of services for persons with co-occurring substance abuse problems, negative staff attitudes toward consumers, not enough attention to the tasks of daily living that clients will need in the community, and violations of patient rights particularly for clients placed out of their home county.

[4] One small, but a bit larger county (50,000-100,000), had an incident in which a mental health client committed murder resulting community reaction which pressured the mental health system to institutionalize a larger number of clients.

A number of participants stressed the difficulty of the transition from an IMD to a community placement. One said, "It's a four foot drop," and "we need to build a ramp, rather than a step-down." One person suggested allowing residents to visit clubhouses while they are still in the IMDs to ease the transition.

PART B: STATEWIDE DATA COLLECTION

Interviews with counties resulted in discrepancies between the statewide data collected by DMH and information from individual counties. We are working with DMH to insure the reliability of the statewide data and will review and analyze this data when this task is accomplished.

PART C: OBSERVATIONS AND CRITERIA FOR SELECTION OF PART II CASE STUDY COUNTIES

Observations

Expanding community living situations for persons with serious mental illness is critically important.

The county interviews were striking in their highlighting of the need for additional housing resources. As noted above, the Mental Health Planning Council has generated a careful analysis of some of the critical issues related to housing and has made a series of recommendations.

The Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force note that while housing resources are essential to implementing solutions to *Olmstead*, "'housing' does not appear in the decision. Instead, the Supreme Court uses terms such as 'community placements' and 'less restrictive settings.'"[5] At the time of the publication of this issue of *Opening Doors* (December 2000) "none of the committees formed, Executive Orders issued, or legislation enacted by states in response to *Olmstead* mentions housing or includes housing officials or experts." And none of the 22 *Olmstead*-related state plans sent to HHS for review mentioned housing.

Fortunately, California's Long Term Care Council does include the Director of the Housing and Community Development (HCD) and its Olmstead Plan acknowledges the importance of housing. The Plan contains information about housing resources available in the state including the Supportive Housing Initiative Act (SHIA) which is a

[5] *Opening Doors: The Olmstead Decision and Housing: Opportunity Knocks.* Technical Assistance Collaborative and the Consortium for Citizens with Disabilities. Issue 12 of *Opening Doors*, December, 2000.

collaboration among the state's Department of Mental Health, HCD, and the Supportive Housing Council. The program has dispensed $48 million for supportive services and rental subsidies to 46 projects, 45 of which have a primary focus on persons who have serious mentally illness. One of the housing recommendations in the plan is "to expand DMH's Supportive Housing program," but the recommendation has the proviso of "subject to additional funds."

The counties confirmed the importance of ACT/AB 34/intensive case management programs in supporting persons in the community.

As expected, counties repeatedly noted the value of intensive outpatient services in sustaining clients in the community. Those that had ACT or AB 34 programs said they had made a difference, and most felt they could use additional slots. And those without such programs had them on their wish list.

In Phase II of the study we hope to examine IMD utilization among clients in such programs to identify policies or practices which may contribute to lower utilization.

Counties differ in their monitoring practices and procedures, and in the proximity of the IMDs utilized to the county. It will be important to assess the impact of these factors on IMD utilization.

Counties varied in the frequency with which they monitored clients in IMDs. Frequency of visits to the facilities where clients were placed ranged from almost daily to quarterly. Generally, counties visited facilities that were located close-by more frequently than those that were further away, and visited facilities in which they had a number of clients more often than facilities where they had only placed one or two clients. Clients with active discharge plans in the near future were often visited more frequently. In Phase II of the study we will examine the impact that the geographic location of the facility and different monitoring practices have on IMD utilization and factors such as length of stay.

In some cases there is a difference between the language of the recovery vision and the realities of IMD use.

The language of those who are managing and working with clients in IMDs does not always synchronize with the recovery vision. As noted above, interviewees frequently used concepts in describing IMDs and their clients that are not consistent with the importance of client driven service plans and activities. While we recognize that some of the more ill clients in IMDs may not be able to participate fully in recovery-oriented programs, it is important to ascertain whether medication and behavioral therapies are being continually tried and evaluated in an effort to ready clients for other recovery-oriented services. Opinions differed on whether MHRCs were more consistent in their recovery orientation than SNF-based IMDs.

Consumers and county systems of care would clearly benefit from a consistency of the recovery perspective throughout the service system. While an assessment of the

functioning of IMDs is beyond the scope of this study, we will attempt to highlight ways in which the IMDs used by our study counties appear to follow or conflict with recovery concepts.

Fiscal pressures provide clear incentives for actions to reduce IMD usage.

Counties were asked what changes, if any, there had been in their level of IMD usage over the last few years. Eight counties indicated significant decreases in overall usage the last two years, reportedly ranging up to 45-50%. In each of these cases, fiscal constraints were cited as the, or one of the reason(s), motivating the change. We plan to include some of these counties in the Phase II part of the study to explore the factors leading to these decisions.

Unfortunately, the same fiscal constraints were cited by a number of counties for the situation either worsening or staying the same because it tightened the availability of alternative community resources.

Understanding the needs of long-stay patients in IMDs is critical to the state's ability to implement Olmstead.

As noted above, there is a subset of consumers whose prospects for discharge appear dim because the counties believe there are no feasible untried community placements. Examining the circumstances of this subset of consumers will be particularly critical in relationship to the dictates of the Olmstead decision. We will explore in Phase II of the study how frequently these consumers receive a full re-assessment that aims to determine whether or not there is a less restrictive placement for them.

Licensing of IMDs and community care facilities create real or perceived problems in using these facilities appropriately and consistently with Olmstead.

The mission of facility licensure is the protection of resident. The Department of Health Services licensing of SNFs and the Department of Social Services licensing of community residential facilities try to ensure that there are no deaths, suicides, substance abuse or other negative occurrences and to give sanctions to and restrictions on facilities where any of these or other dangerous incidents occur. County mental health is responsible for treating individuals who are at greater risk for all of these negative consequences.

Implementing Olmstead and the recovery vision requires that facilities and the community take a reasonable level of risk. Counties identified the need for licensing entities to have a better understanding of mental illness and service programs. The tradeoffs are not easy or always clear-cut, but a more sophisticated dialogue is needed about how to both protect consumers and the community while giving every consumer the best chance for leading a meaningful and productive life.

The role of conservators can influence IMD utilization both to increase it and decrease it not always in relation to the needs of the clients as determined by any objective criteria.

Counties described different attitudes and actions by conservators, which appear to be influenced by factors other than clients' needs. For example, after a major community incident in one county IMD utilization increased substantially. Counties also described conservators willing to continue conservatorship in the community to help clients adjust verses those who dropped the conservatorship as soon as a client was discharged. This problem is not unique to conservatorship but is consistent with issues raised by clients and families about the different implementation of the Lanterman Petris Short Act (LPS) among counties.

Selection of Case Study Counties

The primary purpose of Phase II of the study is to explore reasons for varying rates of IMD usage.

We have identified two major hypotheses regarding (and collected some information about) what accounts for the varying county rates of IMD usage: gate keeping and monitoring procedures and the availability of community placements. There are additional factors that are likely to have an impact:

- Demographic characteristics including size and cultural diversity.
- Levels of overall funding
- Historical usage patterns
- Politics and community tolerance
- Conservatorship issues

The strategy used to select case study counties was as follows:

1. *Usage rates.* The top 10 and the lowest 10 counties were identified.

2. *Explanatory factors.* These 20 counties were weighed on how they stood on the range of explanatory factors cited above, i.e. gate-keeping/monitoring processes; availability of community placements; demographic factors; level of overall funding; historical usage patterns; politics and community tolerance and conservatorship. The purpose is to obtain as much variety on these factors as possible.

3. *Data systems and willingness to participate.* Added weight was given to including counties with good data systems and with high willingness to participate in the study.

Based upon the factors above, the following counties were selected for in-depth information gathering:

- Butte
- Kern
- Los Angeles
- Orange
- San Bernardino
- Santa Clara

All six of the counties selected have agreed to participate in Phase Two of the study.

Appendix A
Counties Interviewed

Alameda
Butte
Contra Costa
El Dorado
Fresno
Humboldt
Kern
Los Angeles
Marin
Mendocino
Merced
Monterey
Napa
Nevada
Orange
Placer
Riverside
Sacramento
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Solano
Sonoma
Stanislaus
Sutter/Yuba
Tuolumne
Ventura
Yolo

Four Counties Under 50,000 in Population
Glenn
Mariposa
Siskiyou
Trinity

Appendix B
County Interview Protocol

County: **Date:** **Persons Interviewed:**

PART I: GENERAL INFORMATION:

We are interested in the numbers and types of IMD/state hospital/MHRC beds your county uses.

1) Which IMDs do you utilize (Note whether state hospitals, MHRCs, SNF, or IMDs)?
_____(_____)_ # of beds _____
_____(_____)_ # of beds _____
_____(_____)_ # of beds _____
_____(_____)_ # of beds _____
_____(_____)_ # of beds _____

2) Are there any differences between the IMDs and the MHRCs? If so, what are the differences?

3) How many clients did you send to IMDs in FY 0l/02? _____
FY 02/03? _____

4) What is your current census at each IMD you use?

Facility: _____ Census _____
Facility: _____ Census _____
Facility: _____ Census _____
Facility: _____ Census _____
Facility: _____ Census _____

5) Have your IMD usage patterns changed in the last three years?
Yes _____ If "yes", please describe how they have changed.
No _____

6) If yes, what caused the changes?

7) Do you know what your recidivism rate is for persons discharged from IMDs in their first year in the community? If so, what is it?

8) How do IMDs fit into your system of care? Are they short term, step down from more acute facilities, long term, for special populations? Please explain how they vary from each other.

PART II – ACCESS AND MONITORING

We are interested in the process by which clients are admitted to your IMDs and the process by which they are monitored while they are there.

9) What kinds of situations/placements do the clients that get placed in IMDs come from?

10) IMD referrals are screened/approved by persons in what role?

11) What documents are used in the process?

12) Do you have a standard form that you use at time of admission? If "yes", please email or fax a copy to us.

13) Do the IMDs you use have treatment plans in place that helps individuals work toward recovery and treatment in the community?

14) Do the IMDs you use have programs which deal with the cultural issues and diversity of their clients?

15) Are standard forms or progress reports from the IMDs used to document progress while County clients are in the IMDs? _____ Frequency of submission _____ Please email or fax copies of any forms to us.

16) How does the County monitor the progress of clients in IMDs?
    By whom?
    How often?

PART III - CLIENT NEEDS:

We are interested in the characteristics of clients that are most difficult to place or maintain in the community. We would also like to know about what makes community placement of difficult clients hard in general, i.e. what community factors in general are barriers to placement for all your clients. And we would like to know what might make a difference for you in addressing these client needs and community barriers.

17) What type clients with mental illnesses are most difficult to serve in the community? Please rank these–with # 1 being the most difficult.

    Substance abusers _____
    Limited intelligence (Incl. But not limited to DD) _____
    Organically impaired _____
    Aggressive or Explosive Personalities _____
    People who do not take medications _____
    Antisocial Personalities _____
    Sexual Offenders _____
    Others _____

18) What resources do you need to get many of your present IMD residents out in the community?

19) What are the three most important general barriers to community placement in your county?

    Lack of income support and entitlements _____
    Lack of affordable housing _____
    Lack of competitive and supported employment _____
    Lack of access to culturally appropriate health care _____
    Fragmented services _____
    Lack of access to culturally appropriate/specific mental health services services _____
    Fiscal barriers to individualized, flexible services _____
    Stigma and discrimination _____
    Undocumented Immigration Status _____
    Legal and/or Conservatorship barriers _____

Staffing shortages _____
Categories? _____
Others _____

20) What are you doing to overcome these barriers?

21) Which of these activities are most promising?

22) Which of these services do you currently have in your county?

Intensive Case Management/Comprehensive Service Programs
(like AB2034, ACT, etc)? _____# slots _____

Residential beds with some programming? _____ # slots _____

Self Help Programs_____# slots or capacity_____

Board and Care Beds (no programming) _____ # slots _____

Board and Care Beds with Supplemental Services (old SB155
model_____# slots_____

Board and Care Beds with county treatment patch_____# slots _____

Programs for Co-Occurring Disorders? _____ # slots _____

Please describe the kinds of Crisis Services that you have.

23) What additional intensive services would be desirable in your county?

24) What do you think the two most important things the State could do to reduce/eliminate your counties use of IMDs?

25) Does your county have unique or special programs that we might want to review in detail in the course of our study? If so, please describe.

26) Would your county be willing to participate in a more detailed study that will closely monitor all persons admitted to IMDs over a 12 to 15 month period?

Questions Added on Conservatorship

27. Who does conservatorship investigation in your county and who is responsible for ongoing conservatorships?
28. Are most of the clients in IMDs on conservatorship?
29. Do the conservators participate in the monitoring process?
30. What is the relationship between the mental health department and the public guardian or conservator?

PLEASE *REMEMBER TO EMAIL, FAX OR SEND US COPIES OF ALL FORMS YOU USE FOR REFERRAL & MONITORING TO:*

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Thank you, Thank you, Thank you!!!